Doing What Counts for Patient Safety: Federal Actions to Reduce Medical Errors and Their Impact

Report of the Quality Interagency Coordination Task Force

February, 2000

Institute of Medicine Report

To Err is Human: Building a Safer Health System

Preventable medical errors

- 44,000 to 98,000 Americans die each year
- Eighth leading cause of death in the United States
- Annual cost as much as $29 billion annually
- IOM conclusion: the majority of these problems are systemic, not the fault of individual providers

Institute of Medicine Report

Four-tiered approach to reducing medical errors

- Establish national focus on patient safety
- Identify and learn from medical errors through mandatory and voluntary reporting systems
- Raise standards and expectations for improvement through oversight, group purchasers, professional groups
- Implement safe practices at the delivery level

Administration Actions on Quality

- Early 1997 - President establishes the Advisory Commission on Consumer Protection and Quality in the Health Care Industry
- 1998 - President establishes the Quality Interagency Coordination (QuIC) Task Force
- 1998 - Vice President launches the National Forum for Health Care Quality Measurement and Reporting

Current Federal Efforts

Research Activities

- Agency for Healthcare Quality and Research (AHRQ)
  - Sponsors research into frequency and causes of medical errors
  - Tests techniques designed to reduce medical errors
- VA Centers for Research on Patient Safety

Current Federal Efforts
Data Collection

- CDC - infections
- FDA - drugs, devices, biologics
- VA reporting system on medical error
- AHRQ - administrative data from hospitals

Current Federal Efforts

Improved Safety Practices

- Veterans Affairs
  - Computerized physician ordering system
  - Computerized patient record system
  - Barcoding technology for medication administration
  - Drug interaction software
- Defense
  - Computerized physician ordering system
  - Drug interaction software

Current Federal Efforts

Health Care Purchasing

- HCFA
  - Medicare “Conditions of Participation” - address quality of care
- Veterans Affairs
  - Uses purchasing power to demand safe packaging/labeling of drugs it buys
- Office of Personnel Management
  - Announced it will require meaningful patient safety programs in all FEHB plans by 2001

Federal Response

- The President directed the QuIC to respond to the IOM's report
  - Evaluate the recommendations in *To Err is Human*
  - Identify prevalent threats to patient safety
  - Identify ways to reduce medical errors throughout the nation's health care system

Federal Response - Leadership

- Establish Center for Quality Improvement and Patient Safety (CQuIPS) at AHRQ:
  - Conduct research into medical errors reduction
  - Convert findings into improved practices
  - Educate patients about their safety
- Conduct National Summits within One Year
  - AHRQ - Patient safety research and practices
  - FDA - Drug and device safety
  - VA - Patient safety practices

Federal Response - Model Programs

- HCFA - Will publish regulations requiring hospitals participating in Medicare to have ongoing medical error programs in place
- OPM - Will require all plans in FEHB to seek accreditation that includes evaluation of patient safety and programs to reduce errors
- VA/DoD - Continue to lead providers by example

Reporting Systems

- Goal: Nationwide system of state-based reporting
- Quality Forum will:
  - Select measures of safety that should be part of any reporting system
  - Identify proven patient-safety practices
  - Define, within 12 months, egregious preventable errors that should never occur
- QuIC to:
  - Urge public disclosure of provider use of Forum-identified proven patient-safety practices
  - Collect, as appropriate select measures that should be part of any reporting system

Reporting Systems - State

- State Mandatory Data Collection to Include
  - Information on select group of errors leading to serious harm or death
  - Information on proven patient safety practices
  - Never a shield for illegal/negligent behavior
- Voluntary component
  - Errors and “close calls”
  - Confidential --- peer review protections
- Data to be shared in national data set for research on patient safety

Reporting Systems - Federal

- HCFA
  - Pilot mandatory reporting in 100 hospitals that volunteer
  - Pilot program with a State with mandatory reporting to test data collection on egregious errors
- VA will add new voluntary data collection to augment existing mandatory
- DoD will institute system modeled on VA system
- OPM will require health plans in FEHB to describe patient safety initiatives in publications

Building on Reporting Systems

- AHRQ
  - Lead effort to evaluate existing reporting systems
  - Include errors in National Quality Report
  - Integrate data from different sources
- VA
  - Establish voluntary system to supplement existing mandatory system

Building on Reporting Systems

- DoD
  - Develop reporting system modeled on VA system - 6 months
- FDA
  - Expand mandatory reporting for blood banks to all 3000 registered blood establishments
  - Implement Phase II of MedSUN

Additional Actions to Improve Safety

- **QuIC**
  - Promote collaborative efforts with public and private sector partners to increase providers' and purchasers' awareness of scope of medical errors problem
  - Collaborative project with Institute for Healthcare Improvement to reduce errors in high hazard settings

Additional Actions for Improving Safety

- **FDA**
  - Improve standards for drug naming, packaging and labeling
  - Conduct public education effort
- **DOL**
  - Encourage health care purchasers to consider patient safety through the Health Benefits Education Campaign

Investment in Improving Safety

- **AHRQ**
  - $20M in FY01 for research into causes and remedies
  - Disseminate approaches to improving patient safety
  - Patient Safety Clearinghouse
  - Expand research on informatics
  - Initiate “National Morbidity & Mortality Conference” via Internet technology
- FDA
  - $33 million for enhanced reporting

Investment in Improving Safety

- **VA**
  - $47.6M to increase patient safety training for staff
  - $75.1M for order entry system, barcoding
- **DoD**
  - $64M in FY01 to introduce electronic medical records
  - $12M for automated order entry system for pharmaceuticals